Exhibit USAbt-X

UNITED STATES DISTRICT COURT

DISTRICT OF MASSACHUSETTS

In re: PHARMACEUTICAL INDUSTRY AVERAGE WHOLESALE PRICE LITIGATION	)	MDL No. 1456 Master File No. 01-CV-12257-PBS
THIS DOCUMENT RELATES TO: United States of America ex rel. Ven-A-Care of the Florida Keys, Inc., et al. v. Dey, Inc., et al., Civil Action No. 05-11084-PBS	)	Judge Patti B. Saris

Video Deposition of C. BENNY RIDOUT, taken by the Defendants, at the Hilton North Raleigh, 3415 Wake Forest Road, Boardroom, Raleigh, North Carolina, on the 5th day of December, 2008 at 9:10 a.m., before Marisa Munoz-Vourakis, Registered Merit Reporter, Certified Realtime Reporter and Notary Public.

MS. YAVELBERG: It's the same question, it's vague.

BY MR. COOK:

Q. Do you understand what I'm asking, Mr. Ridout?

A. Yeah.

Q. Okay, let me ask it again.

From the mailings that you described, what did you learn upon reading them?

MS. YAVELBERG: Objection, form.

A. I learned that there was a discrepancy in what the AWP was and what the pharmacist paid for it.

Q. Did you find any predictable relationship between what the AWP would be and what the pharmacies were paying for those drugs, for generics?

MS. YAVELBERG: Objection, form.

A. Not knowing what the pharmacist actually paid, I had a price list in front of me, but I don't know, and I'm assuming that that company had all pharmacists with that price on

that sheet, but I can't say it was. Or, you know, when it was published, I would have to assume that. Or either what they were buying from that. They might have had a deal better from somebody else, maybe another drug is listed. I didn't see that they were buying from was better than this one.

So I have no idea what the pharmacists were paying for drugs.

Q. You would see the wholesaler list that would tell you the example you gave, the AWP is $100, and we will sell it to you for $30, right, that was the example --

A. That was the example. It was variations by product. Some of them by $10, some of them might be 20 spread, some of them might be 100, some might be 200. That's when I jumped out of my seat.

Q. Some spreads might be $9?

A. Yeah, it depends. Some are close. It depends on the competition and the product as to what kind of range they had.

exactly what the pharmacy had to pay for it and the wholesaler billed it for and everything, because that's the way it was always taught to us.

Q. That was in 1972, right?

A. Yeah '72, '73, '74, we didn't know there was a spread in that.

Q. At some point, did you learn that there was a spread and that -- well, at some point did you learn that there was a spread?

MS. YAVELBERG: Objection, form.

A. Yeah, when they start sending me those price lists, and I can't remember how I picked up on all the other stuff as you say hearsay or whatever.

Q. The drugs that you mentioned that you saw or that you learned had shortages and caused the price to fluctuate, we were talking about that a minute ago, do you recall whether or not Vancomycin was ever such a drug?

A. Yep.

Q. There were shortages of Vancomycin?

A. I don't know about shortages. I remember the price, there was a spread in it. And I was told -- it was not sort of common knowledge at that point that the chemotherapy drugs had an inflated price in them. In fact, I picked that up from a physician.

Q. When did you pick that up?

A. I don't remember the exact year, but when a pharmacist or a physician couldn't get a drug for the price that we had in our system, they would call me and complain, look, you are not even paying me what this drug cost me.

So then I would investigate that drug to see what the price should be, and I would give it to First Data Bank or CMS and said well, you know, I just investigated this drug, and the cost in North Carolina is higher than what the AWP is reported by the manufacturer or First Data Bank, supposedly. And therefore I'm going to have to increase this price. And we could do that based on that documentation I'd keep. Because I would call the wholesaler and ask them what they will

do.

And Vancomycin and some of the other drugs, antibiotics, certain antibiotics were in that class, chemotherapy drugs, the physician called me and told me it was not what he was -- had to pay for the drug, and I happened to know it was a drug that had a spread on it. I said doc, you are already getting paid more anyhow than this extra dollar you are complaining about. He said well, that was built in that anyhow so I could make a profit on selling these drugs.

Q. Do you remember when you had that conversation?

A. No, just a physician.

Q. In the '80s, the '90s?

A. It was quite some while ago. I can't remember. It was probably in the late '80s, mid-'80s. That's a long time ago. It may have been early '90s, who knows. It was discussed more than once during those times. It wasn't just a one-time deal.

In fact, you know, the CMS is closing

any sort of additional payment for the additional services that you described?

MS. YAVELBERG: Objection, form.

A. I'm not aware what they received, but some of them were eligible for some reimbursement through the home health program, the third-party program we had, durable medical equipment, some of the pumps they had to supply and some of the equipment they had to supply, they could bill that through the durable medical equipment program, but it didn't come through the outpatient drug program. We paid for drugs.

Q. You mentioned earlier your belief that given the amount of services that some of these specialty pharmacies were providing, that you were led to believe that they were buying drugs at deeper discounts. Do you recall that testimony?

MS. YAVELBERG: Objection, form.

MS. HAYES: Objection, form.

MS. YAVELBERG: I don't believe that was his testimony.

A. I just said that I don't see how they could do it for that. I have no idea what they were buying it for, what was going on.

Q. Leaving aside the specifics of what they were paying for it, you had an understanding, am I correct, that they were making profit on the drug side?

MS. YAVELBERG: Objection, form.

A. I had to assume that if I was taking ten percent off of that price, and they were providing all this service, that somehow they had to be getting some kind of help from somewhere. I mean, I couldn't see how they can do it with me taking ten percent off of the drug cost and then them providing those extra services and billed for that. That was my opinion.

Q. Did you ever have any conversations with anybody from IV pharmacies about that issue?

A. I used to just try to discuss it with them, but they didn't want to talk to me about drug pricing. In fact, I went to meetings and talked to my providers and told them you know

what was going on? But that was something that they would never volunteer to tell me what they were paying. They would say to me, some of the independents would say we can't buy drugs for what the chains can. And one independent is large, depending on volume, can buy it at a better price than I can.

So it wasn't just that one price fits all, it was based on volume and size of the provider, whether it was a chain, and if it was a chain, was it a North Carolina chain, or was it a national chain, like Walgreens and Eckerds and those, they were supposed to get better prices than Kerr, the local chain.

So it's just all kinds of pricing modes and mechanism in place. There was no one set price, and that's one reason why when I tried to adjust my AWP, how do you adjust the AWP to cover everybody, not knowing what it is?

Q. The price list that you had received from wholesalers, did those ever relate to infusion or home IV drugs?

A. Most of the time it did not. But most of the time the manufacturers would come in and want us to make sure we had that price in the system, because they were working with that specialty pharmacist to get that drug out.

You know, I can remember sometimes the company itself would contract with a K-Mart or specialty pharmacist to promote that drug and they would make that drug available to that specialty pharmacist and that specialty pharmacist would get all the physicians and try to recruit that business with the help of the manufacturer.

Q. And when you are referring to that sort of detailing with respect to a particular drug, you are referring to a brand drug?

MS. YAVELBERG: Objection, form.

A. I would have to say most of the time it's probably a brand. There could be some generic, in fact, some of them went generic, some of those specialty drugs I've seen that went generic over a period of time. So originally it

Q. We will get to that study in a minute, but if that study was in 1984, you would agree with me that by 1984, you no longer believed that average whole sale prices were surveyed prices that represented an average of prices charged by wholesalers?

MS. YAVELBERG: Objection, form.

MS. HAYES: Objection, form.

A. Yeah, at that time, I didn't know what pricing, what was going on in pricing, except that we had heard that pharmacies were buying drugs below what we were -- AWP. That's all we heard, not even knowing whether it was two percent, one percent, and some pharmacists claimed they had to pay AWP, so we heard everything.

Q. The conversations with Ms. Shipley, getting back to that, you never asked Ms. Shipley for pricing information even regarding the drugs that you saw on mailings from wholesalers, right?

A. Never asked her for pricing information, because that's not where I picked up

hospital, a nursing home, trying to get a wide range of providers, so it would give us an overall view of what's going on with the discounts, what they were actually paying, not knowing what it would be, but we wanted all providers represented, and we felt like that they didn't understand that we found us leading them to that, they wouldn't understand how the providers differed, the pharmacists, the business, they were just auditors.

So we discussed that with them and came up with this and we helped write the letter that went out to the pharmacists, and, of course, they chose these states that we brought here, okay, since you are all here, we are talking, use your all states. Of course they used some more, I think, besides this.

Q. If you look at the summary here in the second paragraph under comments, they indicate that: "The state officials expressed concern that our review is limited to one aspect of pharmacy reimbursement. They said that any effort to

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lower the reimbursement acquisition cost should also include the sum review of dispensing fees."

Do you recall a discussion of that during your meetings in Richmond?

A. Yeah.

Q. And what was that discussion?

A. Well, it was like I described earlier, you know, sometimes dispensing fee didn't cover all the true costs, especially some types of providers that we discussed. And if you lowered, they were sent as a range there, if you lowered this side to where just down to what they actually paid for it, and then the fee doesn't actually cover it, and we were required, supposed to, by federal regulations, to do a dispensing fee survey, it said periodically, and we tried to get the Feds to interpret that, what does that word mean? And they leave it up to the state as to what fee we pay and how often we did a survey.

Well, the states were really slacking doing surveys, all the costs had gone up. Sometimes we would adjust our fee based on

inflationary factors, and, of course, the survey costs so much to do. If you hire somebody like Myers and Stauffer or somebody else to come in and do a survey, it was a lot of money.

So we really did not adjust the fees like we should. And we knew it was lower than it should be. If you want to look at our fee in North Carolina, it's been the same thing for the last 15 years, I guess. Well, you know, it cost more than that to fill a prescription than it did 15 years ago.

So they are not getting paid what they should be getting paid. And then they were living on part of that little spread. We knew there was some spread. We didn't know it was as big as it was.

So if you do away with all that spread and get to the actual acquisition cost, and you want somebody to fill prescriptions for you, you are going to have to raise the fee and there ain't going to be nobody.

Q. Did you have any amount in mind that

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was necessary in order to make up for the shortfalls in the dispensing fee?

MS. YAVELBERG: Objection to form.

A. Not without doing the dispensing fee survey. We didn't know what it would be. I have had some done recently. Since I retired, I've seen some. It was to be $10 or $12, it varies from state to state, what it actually costs a pharmacist to fill a prescription. And that's an average too. When it comes out, Myers and Stauffer, anybody does one, they give you an average, but sometimes in one pharmacy it may cost him 15, another one may cost 10, but that's an average, see, that's what we pay based on averages.

Q. Do you recall which specifically of the state officials expressed these concerns as described in Ridout 5?

MS. YAVELBERG: Objection, form.

BY MR. COOK:

Q. That's the -- if you look at the paragraph, the state officials expressing concern

Sunday night and get the price down where it should be in line. That will be it. Let them advertise their price. Let them do what they want to. They will bring them down in line, and we can all leave here and it will be resolved.

I also told them at the time I said, you also could request a First Data Bank or the states not put anything in the computer greater than 20 percent above what the wholesaler cost is, and that's for the wholesaler to make some money when he sells it to the pharmacist and the pharmacist to make a little off of it when he buys it. But we would know what percentage he was getting, and in fact, it was common practice that a lot of the ethical pharmaceutical companies were 20 percent markup companies and they will give their price to First Data Bank with a 20 percent markup on it, and it wasn't inflated to 100 percent or 200 percent or 300 percent like some of them were.

And basically that's what went during the discussion at that meeting. And we left